Part 6. Error Codes and Explanations

This part defines the error codes that may appear on your paper remittance advice. Pharmacy providers may also encounter them during an online transaction. Errors identified as "MassHealth use only" do not affect the status of a claim and, in most instances, are invisible to you. If you also use the electronic 835 remittance advice transaction to reconcile your accounts, you should refer to the Crosswalk of Adjustment Reason and Remarks Codes that is available on the MassHealth Web site.

For more information about how to correct a claim, see Part 7 of the administrative and billing instructions. Provider manuals are available in the Provider Library on the MassHealth Web site. Go to www.mass.gov/masshealth, click on MassHealth Regulations and Other Publications, then on Provider Library. Pharmacy providers should refer to the NCPDP specifications, or contact their software vendor about online transactions.

Code	Description
001	The copayment review amount has been reached.
002	The claim payment amount is less than the copayment amount.
003	The pay-to provider number entered on the claim is invalid. If it is now over 90 days from the date of service, you can request a 90-day waiver.
004	The member identification number is either missing or invalid. Verify the RID number through REVS. If it is now over 90 days from the date of service, you can request a 90-day waiver.
005	The accident type code is either missing or invalid.
006	The to-date of service entered on the claim is invalid for consecutive dates of service.
007	The member identification number is either missing or invalid. Verify the RID number through REVS. If it is now over 90 days from the date of service, you can request a 90-day waiver.
008	The prior-authorization number entered on the claim is invalid.
009	The member's Medicare identification number is either missing or invalid. Verify the HIC number through REVS.
010	The member identification number is either missing or invalid. Verify the RID number through REVS.
011	The servicing provider number entered on the claim is invalid.
012	The procedure code is either missing or invalid.
013	Partial copayment applied.
014	The usual fee is either missing or invalid.
015	The other paid amount entered on the claim is invalid.
016	MassHealth use only
017	MassHealth use only
018	There was a submission error on the claim.
019	MassHealth use only
020	MassHealth use only

Code	Description
021	The action code is either missing or invalid.
022	The level-of-care code is either missing or invalid.
023	MassHealth use only
024	The patient status code entered on the claim conflicts with the type-of-bill code entered on the claim.
025	The revenue code entered on the claim conflicts with the type-of-bill code entered on the claim.
026	The patient status code is either missing or invalid.
027	The billing date is either missing or invalid.
028	The admission date is either missing or invalid.
029	The date of birth is either missing or invalid. Correct the date of birth entered on the POPS transaction.
030	The Medicare number on the Medicare/Medicaid crossover claim does not match the Medicare number listed on the MassHealth eligibility file. Verify the member's recipient identification (RID) and health insurance claim (HIC) numbers through REVS.
031	The gender code is either missing or invalid. Correct the gender code entered on the POPS transaction.
032	The other coverage code is either missing or invalid. Correct the other coverage code entered on the POPS transaction.
033	The total charge is either missing or invalid.
034	The primary payer date is either missing or invalid. Correct the primary payer date entered on the POPS transaction.
035	Medicare made full payment on the claim. Additional payment will not be made by MassHealth.
036	Medicare denied this claim; therefore, the claim must be billed on a MassHealth claim form with the Medicare EOB as an attachment.
037	MassHealth use only
038	The place-of-service code is either missing or invalid.
039	MassHealth use only
040	MassHealth use only
041	The first or last name is either missing or invalid. Correct the first or last name entered on the POPS transaction.
042	The compound drug code is either missing or invalid.
043	The patient-paid amount entered on the claim is invalid.
044	The NDC is either missing or invalid. Correct the NDC entered on the POPS transaction.
045	The procedure code entered on the claim does not have a determined rate on file.

Code	Description
046	MassHealth use only
047	MassHealth use only
048	A HCPCS procedure code is required for dates of service on or after 04/01/91.
049	The procedure code modifier entered on the claim is not covered by MassHealth.
050	The procedure code modifier entered on the claim is invalid.
051	The procedure code modifier entered on the claim cannot be billed with the service code entered on the claim.
052	The admit-from code is either missing or invalid.
053	The procedure code modifier entered on the claim is not covered by MassHealth.
054	The dates of service, patient status, and covered days entered on the claim conflict.
055	The number of days is either missing or invalid.
056	The prescription number is either missing or invalid. Correct the prescription number entered on the POPS transaction.
057	The member is restricted to a primary pharmacy. The number of days' supply entered on the POPS transaction exceeds the maximum number allowed.
058	A less costly method of service or treatment is available.
059	MassHealth use only
060	This service is not payable by MassHealth.
061	A report containing a higher level of detail must be submitted.
062	The procedure code entered on the claim is incorrect for this service.
063	The procedure code modifier entered on the claim is incorrect for this service.
064	The date filled is either missing or invalid. Correct the filled date entered on the POPS transaction.
065	This service is a component of a primary procedure for which payment has been made. This component will not be paid separately.
066	The days' supply is either missing or invalid. Correct the days' supply entered on the POPS transaction.
067	Payment for this service has been made to another physician.
068	The date filled conflicts with the claim media. Submit this claim as a POPS transaction.
069	MassHealth use only
070	The provider did not accept Medicare assignment. MassHealth will not pay for services when assignment is not accepted.
071	The provider does not have access to the POPS system.
072	From and to dates of service are not allowed for this service. Enter a single date of service on the claim or bill another service code.

Code	Description
073	MassHealth use only
074	The drug certification code entered on the claim is invalid.
075	MassHealth use only
076	MassHealth use only
077	The date filled is before the effective dates on the NDC standard package size record.
078	A CLIA certification number is not on file. Contact MassHealth Provider Enrollment and Credentialing.
079	The date of service entered on the claim is before the effective date of CLIA certification.
080	The date of service entered on the claim is after the expiration date of CLIA certification.
081	The CLIA certification information on file does not allow for payment for this service.
082	The date of accident is either missing or invalid.
083	MassHealth use only
084	MassHealth use only
085	MassHealth use only
086	The member's Senior Pharmacy Program benefits have been exhausted.
087	MassHealth use only
088	The value code entered on the claim conflicts with the patient status code entered on the claim.
089	The type of admission entered on the claim is invalid.
096	This claim is a duplicate of a previously paid claim.
097	MassHealth use only
098	A claim for the extraction of this tooth was previously paid.
099	The procedure code entered on the claim is incorrect for this service.
100	This claim is a potential duplicate of a claim previously paid for similar services.
101	This claim is a potential duplicate of a claim previously paid for similar services.
102	This is a duplicate TCN. Pharmacy providers use this information to reverse a previously paid claim.
103	This claim is a duplicate of a previously paid claim.
104	The total number of allowed visits for this procedure has been exceeded.
105	The combination of this procedure and at least one other, submitted either on the same claim form or on a previous claim form, for the same member, on the same date of service, to the same provider is not allowed.
106	Payment of an office visit and surgical procedure for the same member, on the same date of service, to the same provider is not allowed. A claim for one of these services has been previously paid.
107	This claim is a potential duplicate of a claim previously paid for similar services.

Code	Description
108	This claim is a potential duplicate of a claim previously paid for similar services (applicable to long term care claims.)
109	Payment of multiple visits for the same member, on the same date of service, to the same provider is not allowed. A claim for a visit on this date of service has been previously paid.
110	The combination of this procedure and at least one other, submitted either on the same claim form or on a previous claim form, for the same member, on the same date of service, to the same provider is not allowed.
111	This claim is a duplicate of a claim previously paid for medical services for the same date of service.
112	This claim is a duplicate of a claim previously paid as a Medicare/MassHealth crossover claim for the same date of service.
113	This claim is a duplicate of a claim previously paid for the same date of service.
114	This service is a component of a comprehensive procedure for which payment has been made. This component will not be paid separately.
115	This component of a comprehensive service has already been paid.
116	The combination of this procedure and at least one other comprehensive and bundling procedure submitted either on the same claim form or on a previous claim form, for the same member, on the same date of service, to the same provider is not allowed.
119	This claim requires review.
120	The Certification for Payable Abortion form requires review.
121	The Hysterectomy Information form requires review.
122	The Sterilization Consent form requires review.
123	This claim requires review.
124	The NDC requires review.
125	This void transaction requires review.
126	This claim requires medical review.
127	The procedure code entered on the claim is not covered by MassHealth.
128	The NDC is not covered by MassHealth.
129	The provider specialty information on file does not permit payment for the procedure code entered on the claim.
130	The provider specialty information on file does not permit payment for this procedure.
131	The diagnosis code is missing. The procedure code entered on the claim requires that a diagnosis code be entered on the claim.
132	The procedure requires review of a report.
134	The shoe prescription form attachment was not submitted with the claim.
135	The procedure code modifier is missing. The procedure code entered on the claim requires a procedure code modifier.

Code	Description
136	The procedure code modifier entered on the claim does not match the procedure code modifier on the prior authorization.
137	The NDC was not covered by MassHealth on the date of service.
138	The drug is not covered; however, a prior-authorization number is present that may allow coverage in this instance.
139	The NDC cannot be billed by this pharmacy.
141	The from and through dates of service entered on the claim span both a contractual and non-contractual period. The claim must be split-billed.
142	The from and through dates of service entered on the claim span months. The claim must be split-billed.
143	The from date of service entered on the claim must precede the to date of service entered on the claim.
144	From and through dates of service are not allowed. Enter a single date of service on the claim.
145	MassHealth use only
146	MassHealth use only
147	MassHealth use only
148	The patient status code is either missing or invalid.
149	The member for whom you are billing is not enrolled in hospice care.
150	MassHealth use only
151	The ProDUR therapeutic duplication indicates that the prescription being dispensed is a duplicate of a previously dispensed (active) prescription. The same provider number and different prescriber numbers exist among the previous and current claims.
152	The ProDUR therapeutic duplication indicates that the prescription being dispensed is a duplicate of a previously dispensed (active) prescription. The same provider number and different prescriber numbers exist among the previous and current claims.
153	The units of service entered on the claim exceed the amount remaining under the prior-authorization number entered on the claim.
154	The prior-authorization number entered on the claim has been voided.
155	The procedure code modifier entered on the claim is invalid for this provider.
156	The place-of-service code entered on the claim conflicts with the procedure code entered on the claim.
157	The procedure code modifier is missing. The procedure code entered on the claim requires a procedure code modifier when the place-of-service code entered on the claim indicates an inpatient or outpatient hospital setting.
158	The member identification number entered on the claim is not the member identification number listed under the prior-authorization number entered on the claim.
159	The provider number entered on the claim is not the provider number listed under the prior-authorization number entered on the claim.

Code	Description
161	The former TCN entered on the adjustment claim is incorrect.
162	The former TCN entered on the adjustment claim is incorrect. It corresponds to a previously denied claim.
163	The amount paid by MassHealth on the voided claim does not match the amount paid by MassHealth on the original claim.
164	This returned-check transaction requires review.
165	This voided returned-check transaction requires review.
166	The former TCN entered on the adjustment claim is invalid.
167	This claim is a potential duplicate. An adjustment claim referencing the same former TCN is currently in process.
168	This claim is a potential duplicate. A resubmittal claim referencing the same former TCN is currently in process.
169	The amount of the returned check transaction exceeds the amount paid by MassHealth on the original claim.
170	The month or year of service entered on the adjustment claim does not match the month or year of service entered on the original claim.
171	The former TCN entered on the adjustment claim conflicts with the procedure code entered on the adjustment claim. The former TCN corresponds to an original claim that was not an EPSDT assessment or it corresponds to an original claim that was an EPSDT assessment.
172	The former TCN entered on the resubmittal claim is incorrect. It corresponds to a previously paid claim.
173	The ProDUR drug-to-drug interaction code is severity 1. The same provider number and different prescriber numbers exist among the previous and current claims.
174	The ProDUR drug-to-drug interaction code is severity 2. The same provider number and different prescriber numbers exist among the previous and current claims.
175	The ProDUR drug-to-drug interaction code is severity 1. Different provider numbers and different prescriber numbers exist among the previous and current claims.
176	The ProDUR drug-to-drug interaction code is severity 2. Different provider numbers and different prescriber numbers exist among the previous and current claims.
178	The procedure code entered on the claim is not covered for this provider.
180	The provider-specific rate is not on file for the date of service entered on the claim.
181	The provider-specific case-mix rate is not on file for the dates of service entered on the claim.
182	MassHealth use only
183	The provider-specific case-mix rate is not on file for the dates of service entered on the claim.
184	This claim was paid at $0.00 in accordance with MassHealth policy.
185	The report is missing. The procedure code entered on the claim requires review of a report.
186	This claim requires review.

Code	Description
187	The procedure code entered on the claim is not covered for members enrolled in this coverage type. The member is enrolled in category of assistance 04 (EAEDC).
188	The procedure code entered on the claim is not covered for members enrolled in this coverage type.
189	The ProDUR therapeutic overlap conflict code is severity 1. The same provider number and different prescriber numbers exist among the previous and current claims.
190	The ProDUR therapeutic overlap conflict code is severity 2. The same provider number and different prescriber numbers exist among the previous and current claims.
191	The quantity is either missing or invalid. Correct the drug quantity entered on the POPS transaction.
192	The Certification of Medical Necessity form requires review.
193	The Certification of Medical Necessity is missing. The procedure code entered on the claim requires that Certification of medical Necessity form.
194	The ProDUR therapeutic overlap conflict code is severity 1. Different provider numbers and different prescriber numbers exist among the previous and current claims.
195	The ProDUR therapeutic overlap conflict code conflict code is severity 2. Different provider numbers and different prescriber numbers exist among the previous and current claims.
196	The ProDUR drug to age conflict code is severity 1. The NDC being billed is contraindicated for the member's age.
197	The compound drug information is either missing or invalid.
198	This claim requires review.
199	This compound drug claim requires review.
200	The former TCN on the adjustment claim is missing.
201	The ProDUR therapeutic duplication indicates that the prescription being dispensed is a duplicate of a previously dispensed (active) prescription. Different provider numbers exist among the previous and current claims.
202	The prior-authorization number entered on the claim is not on file.
203	The member identification number entered on the claim is not on file. Verify the RID number through REVS.
204	The member identification number entered on the claim is not on file. Verify the RID number through REVS.
205	MassHealth use only
206	The referring provider number entered on the claim is not on file.
207	MassHealth use only
208	The ProDUR drug-to-drug interaction code is severity 1. The same provider number and the same prescriber number exist among the previous and current claims.
209	The prescriber number entered on the claim is missing or invalid.

Code	Description
210	This claim requires review. The procedure code entered on the claim normally requires a letter of second opinion, but an emergency is indicated.
211	The ProDUR drug-to-drug interaction code is severity 3. The same provider number exists among the previous and current claims.
212	The ProDUR drug-to-drug conflict code is severity 4. The same provider number exists among the previous and current claims.
213	The ProDUR drug-to-drug conflict code is severity 5. The same provider number exists among the previous and current claims.
214	MassHealth use only
215	The from date of service entered on the claim must precede the to date of service entered on the claim.
216	The ProDUR therapeutic duplication indicates that the prescription being dispensed is a duplicate of a previously dispensed (active) prescription. The same provider number and the same prescriber number exist among the previous and current claims.
217	MassHealth use only
218	MassHealth use only
219	The former TCN entered on the adjustment claim is incorrect. It corresponds to a previously adjusted or voided claim.
220	The former TCN entered on the adjustment claim is incorrect. It corresponds to a previously denied claim.
221	This returned-money or void transaction cannot be processed. It corresponds to a previously adjusted or voided claim.
222	This returned-money or void transaction cannot be processed. It corresponds to a previously denied claim.
223	This returned-money or void transaction cannot be processed. The amount on this and the matching claim are not equal.
224	This claim awaits an archive run due to the date of service entered on the claim.
225	This claim was received for processing before the billing date entered on the claim.
226	The procedure code modifier entered on the claim requires review.
227	This claim was received for processing before the date of service entered on the claim.
228	The billing date entered on the claim must be on or after the date of service entered on the claim.
229	The procedure code entered on the claim is not on file.
230	MassHealth use only
231	MassHealth use only
232	The pay-to provider number entered on the claim is not on file.
233	The servicing provider number entered on the claim is not on file.

Code	Description
234	The servicing provider number is missing.
235	This claim requires review.
236	This claim requires review.
237	The member has Medicare coverage on the date of service entered on the claim. Submit this claim to Medicare.
238	MassHealth use only
239	The NDC entered on the claim is not on file.
240	The NDC entered on the POPS transaction is not on file.
241	The ProDUR therapeutic overlap conflict code is severity 2. The same provider number and same prescriber number exist among the previous and current claims.
242	MassHealth use only.
243	MassHealth use only
244	The member identification number entered on the claim is ineligible on the date of service entered on the claim. Verify the RID number through REVS.
245	The member identification number entered on the claim is ineligible on the date of service entered on the claim. Verify the RID number through REVS.
246	The member identification number entered on the claim is ineligible on the date of service entered on the claim. Verify the RID number through REVS.
247	The member has MCO coverage on the date of service entered on the claim. Submit this claim to the MCO.
248	The ProDUR therapeutic overlap conflict code is severity 4. The same provider number exists among the previous and current claims.
249	The ProDUR therapeutic overlap conflict code is severity 5. The same provider number exists among the previous and current claims.
250	The ProDUR early refill conflict code indicates that the member may be noncompliant with the prescription because of the timeliness of the refill, which is more than 40 days early.
251	The pay-to provider number entered on the claim is ineligible on the date of service entered on the claim.
252	This type of claim form may not be used by this provider.
253	The procedure code entered on the claim is not covered by MassHealth for members of this gender.
254	The procedure code entered on the claim is not covered by MassHealth for members of this age.
255	The procedure code entered on the claim requires prior authorization.
256	The procedure code entered on the claim is not the procedure code listed under the prior-authorization number entered on the claim.
257	The procedure code entered on the claim is incorrect for this service.

Code	Description
258	The procedure code entered on the claim requires that a prior-authorization number be entered on the claim.
259	The procedure code entered on the claim cannot be billed on this type of claim form.
260	The procedure code and/or revenue code entered on the claim requires that a prior-authorization number be entered on the claim.
261	The ProDUR early refill conflict code indicates that the member may be noncompliant with the prescription as determined by the timeliness of the refill, which is from 20 to 40 days early.
262	This claim requires review.
263	A ProDUR conflict code exists.
264	The ProDUR early refill conflict code indicates that the member may be noncompliant with the prescription dispensed as determined by the timeliness of the refill, which is from eight to 10 days early.
265	MassHealth use only
266	The from and to dates of service entered on the claim span the conversion to HCPCS procedure codes. MMPCS codes must be used for services before April 1, 1991. HCPCS procedure codes must be used for services on and after April 1, 1991. This claim must be split-billed.
267	The from and to dates of service entered on the claim span state fiscal years. This claim must be split-billed.
268	MassHealth use only
269	MassHealth use only
270	MassHealth use only
271	MassHealth use only
272	MassHealth use only
273	The ProDUR drug-to-drug conflict code is severity 1. Different provider numbers and the same prescriber number exist among the previous and current claims.
274	The ProDUR drug-to-drug conflict code is severity 2. Different provider numbers and the same prescriber number exist among the previous and current claims.
275	The procedure code entered on the claim cannot be billed on this type of claim form.
276	This claim requires review.
277	The procedure code entered on the claim is not covered by MassHealth on the date of service entered on the claim for members enrolled in this coverage type.
278	The procedure code entered on the claim is not covered by MassHealth on the date of service entered on the claim.
279	The date of service entered on the claim conflicts with the payment methodology on file for the procedure code entered on the claim.
280	The amount paid by Medicare for this claim exceeds the amount allowed by MassHealth for the service; therefore, no additional payment will be made by MassHealth.

Code	Description
281	This claim requires review.
282	This claim requires review.
283	MassHealth use only
284	The combination of this procedure and at least one other, submitted either on the same claim form, or on a previous claim form, for the same member, on the same date of service is not allowed. This procedure is paid only when performed independently of other surgical procedures.
285	This claim is a potential duplicate of a claim previously paid for similar services. The servicing provider number entered on the claim is the same for both the primary and assistant surgeons.
286	The procedure code modifier is missing. The combination of this procedure and at least one other submitted either on the same claim form, or on a previous claim form, for the same member, on the same date of service requires that a multiple-surgery procedure code modifier be entered on this claim.
287	The former TCN entered on the adjustment claim is incorrect. It corresponds to a claim previously paid at zero dollars.
288	The combination of this procedure and at least one other, submitted either on the same claim form, or on a previous claim form, for the same member, on the same date of service is not allowed. This procedure is paid only when performed independently of other procedures.
289	MassHealth use only
290	This claim requires review.
291	The maximum frequency limitation for the procedure code entered on the claim, for this member, has been exceeded.
292	The number of units entered on the claim exceeds the total cumulative number of units allowed for the procedure code entered on the claim.
293	MassHealth use only
294	This claim requires review.
295	The ProDUR drug-to-drug conflict code is severity 3. Different provider numbers exist among the previous and current claims.
296	This claim was received for processing more than 90 days after the date of service entered on the claim. You can request a 90-day waiver.
297	The ProDUR drug-to-drug conflict code is severity 4. Different provider numbers exist among the previous and current claims.
298	The ProDUR drug-to-drug conflict code is severity 5. Different provider numbers exist among the previous and current claims.
299	The ProDUR therapeutic duplication conflict code indicates that the prescription being dispensed is a duplicate of a previously dispensed (active) prescription. Different provider numbers and the same prescriber numbers exist among the previous and current claims.
300	The ProDUR therapeutic overlap conflict code is severity 1. Different provider numbers and the same prescriber number exist among the previous and current claims.

Code	Description
301	The value code entered on the claim conflicts with the number of covered days entered on the claim. A standard payment amount per discharge (SPAD) claim cannot exceed 20 covered days.
302	The value code entered on the claim conflicts with the noncovered days entered on the claim.
303	MassHealth use only
304	This claim requires review.
305	The ProDUR therapeutic overlap conflict code is severity 2. Different provider numbers and the same prescriber number exist among the previous and current claims.
306	The ProDUR therapeutic overlap conflict code is severity 3. Different provider numbers exist among the previous and current claims.
307	The ProDUR therapeutic overlap conflict code is severity 4. Different provider numbers exist among the previous and current claims.
308	This service is not covered by MassHealth for members of this age.
309	MassHealth use only
310	The principal surgical procedure code entered on the claim is invalid.
311	The principal surgical procedure code entered on the claim is not on file.
312	The principal surgical procedure code entered on the claim is not covered by MassHealth for members of this gender.
313	The principal surgical procedure code entered on the claim is not covered by MassHealth for members of this age.
314	The principal surgical procedure code entered on the claim is not covered by MassHealth.
315	MassHealth use only
316	The principal surgical procedure code entered on the claim requires review.
317	The principal surgical procedure code entered on the claim was not covered by MassHealth on the from and through dates of service entered on the claim.
318	The ProDUR therapeutic overlap conflict code is severity 5. Different provider numbers exist among the previous and current claims.
319	The principal surgical procedure code is missing.
320	The second surgical procedure code entered on the claim is invalid.
321	The second surgical procedure code entered on the claim is not on file.
322	The second surgical procedure code entered on the claim is not covered by MassHealth for members of this gender.
323	The second surgical procedure code entered on the claim is not covered by MassHealth for members of this age.
324	The second surgical procedure code entered on the claim is not covered by MassHealth.
325	MassHealth use only

Code	Description
326	The second surgical procedure code entered on the claim requires review.
327	The second surgical procedure code entered on the claim was not covered by MassHealth on the from and through dates of service entered on the claim.
328	MassHealth use only
329	The second surgical procedure code is missing.
330	The third surgical procedure code entered on the claim is invalid.
331	The third surgical procedure code entered on the claim is not on file.
332	The third surgical procedure code entered on the claim is not covered by MassHealth for members of this gender.
333	The third surgical procedure code entered on the claim is not covered by MassHealth for members of this age.
334	MassHealth use only
335	MassHealth use only
336	The third surgical procedure code entered on the claim requires review.
337	The third surgical procedure code entered on the claim was not covered by MassHealth on the from and through dates of service entered on the claim.
338	MassHealth use only
339	The third surgical procedure code is missing.
340	The eligibility clarification code is either missing or invalid. Correct the eligibility clarification code entered on the POPS transaction.
341	The principal surgical procedure date is either missing or invalid. Surgical dates must be in MM/DD format.
342	The second surgical procedure date is either missing or invalid. Surgical dates must be in MM/DD format.
343	The third surgical procedure date is either missing or invalid. Surgical dates must be in MM/DD format.
344	The principal surgical procedure date entered on the claim conflicts with the from and through dates of service entered on the claim.
345	The second surgical procedure date entered on the claim conflicts with the from and through dates of service entered on the claim.
346	The third surgical procedure date entered on the claim conflicts with the from and through dates of service entered on the claim.
347	The gender code is either missing or invalid. Correct the gender code entered on the POPS transaction.
348	The gross amount due is either missing or invalid. Correct the gross amount due entered on the POPS transaction.
349	MassHealth use only

Code	Description
350	Documentation is missing. The procedure code entered on the claim requires supporting documentation.
351	The Sterilization Consent form is missing. The procedure code entered on the claim requires a Sterilization Consent form.
352	The Sterilization Consent form is incomplete.
353	The Sterilization Consent form is not completed in accordance with state and federal regulations.
354	This claim is illegible.
355	The report is illegible.
356	MassHealth use only
357	MassHealth use only
358	This claim requires review.
359	This claim requires review.
360	A request for additional information was made, the additional information was not received.
361	This service is a component of a comprehensive procedure for which payment has been made. This incidental procedure will not be paid separately.
362	The authorized signature is missing on the Claim Correction form.
363	The authorized signature is missing.
364	A usual and customary fee must be entered on the claim for each procedure or revenue code entered on the claim.
365	Two Claim Correction forms were completed, but the returned information is incorrect.
366	MassHealth use only
367	The Hysterectomy Information form is not completed in accordance with state and federal regulations.
368	The Hysterectomy Information form is missing. The procedure code entered on the claim requires a Hysterectomy Information form.
369	The Hysterectomy Information form is incomplete.
370	The Hysterectomy Information form is not acceptable, according to current MassHealth regulations.
371	The Sterilization Consent form is not acceptable, according to current MassHealth regulations.
372	MassHealth use only
373	The member has Medicare supplemental insurance coverage on the date of service entered on the claim. Submit this claim to the supplemental insurer.
374	The member's Medicare identification number entered on the claim conflicts with the member's Medicare identification number on the member eligibility file. Verify the HIC number through REVS.

Code	Description
375	The Medicare deductible amount is not numeric. Verify the deductible amount reported by Medicare.
376	The Medicare coinsurance amount is not numeric. Verify the coinsurance amount reported by Medicare.
377	The Medicare type of service code entered on the claim is invalid.
378	MassHealth use only
379	MassHealth use only
380	MassHealth use only
381	The Medicare pay-to-provider number is invalid.
382	MassHealth use only
383	MassHealth use only
384	MassHealth use only
385	The Medicare provider number entered on the claim is not on the MassHealth provider file. Contact MassHealth Customer Services Provider Enrollment.
386	The NDC entered on the claim is not on file on the date filled.
387	This claim requires review.
388	This claim requires review.
389	This claim requires review.
390	The number of noncovered days entered on the claim is invalid.
391	MassHealth use only
392	This claim requires review.
393	This claim requires review.
394	This claim requires review.
395	This claim requires review.
396	This claim requires review.
397	This claim requires review.
398	This claim requires review.
399	The diagnosis code entered on the claim is invalid on the date of service entered on the claim.
400	The diagnosis code is either missing or invalid.
401	The diagnosis code entered on the claim is not on file.
402	The diagnosis code entered on the claim is not covered by MassHealth for members of this gender.
403	The diagnosis code entered on the claim is not covered by MassHealth for members of this age.

Code	Description
404	The diagnosis code entered on the claim is not covered by MassHealth.
405	MassHealth use only
406	MassHealth use only
407	The diagnosis code entered on the claim conflicts with the procedure code entered on the claim.
408	The diagnosis code entered on the claim must be more specific.
409	The ProDUR therapeutic overlap conflict code is severity 1. The same provider number and the same prescriber number exist among the previous and current claims.
410	The primary diagnosis code is either missing or invalid.
411	The primary diagnosis code entered on the claim is not on file.
412	The primary diagnosis code entered on the claim is not covered by MassHealth for members of this gender.
413	The primary diagnosis code entered on the claim is not covered by MassHealth for members of this age.
414	The primary diagnosis code entered on the claim is not covered by MassHealth.
415	MassHealth use only
416	The primary diagnosis code entered on the claim requires review.
417	The primary diagnosis code entered on the claim is invalid on the date of service entered on the claim.
418	MassHealth use only
420	The second diagnosis code entered on the claim is invalid.
421	The second diagnosis code entered on the claim is not on file.
422	The second diagnosis code entered on the claim is not covered by MassHealth for members of this gender.
423	The second diagnosis code entered on the claim is not covered by MassHealth for members of this age.
424	MassHealth use only
425	MassHealth use only
426	The second diagnosis code entered on the claim requires review.
427	The second diagnosis code entered on the claim is invalid on the date of service entered on the claim.
428	MassHealth use only
429	The ProDUR therapeutic overlap conflict code is severity 1. The same provider number and the same prescriber number exist among the previous and current claims.
430	The third diagnosis code entered on the claim is invalid.
431	The third diagnosis code entered on the claim is not on file.

Code	Description
432	The third diagnosis code entered on the claim is not covered by MassHealth for members of this gender.
433	The third diagnosis code entered on the claim is not covered by MassHealth for members of this age.
434	MassHealth use only
435	MassHealth use only
436	The third diagnosis code entered on the claim requires review.
437	The third diagnosis code entered on the claim is invalid on the date of service entered on the claim.
438	MassHealth use only
440	The fourth diagnosis code entered on the claim is invalid.
441	The fourth diagnosis code entered on the claim is not on file.
442	The fourth diagnosis code entered on the claim is not covered by MassHealth for members of this gender.
443	The fourth diagnosis code entered on the claim is not covered by MassHealth for members of this age.
444	MassHealth use only
445	MassHealth use only
446	The fourth diagnosis code entered on the claim requires review.
447	The fourth diagnosis code entered on the claim is invalid on the date of service entered on the claim.
448	MassHealth use only
449	The level-of-service code is either missing or invalid.
450	The fifth diagnosis code entered on the claim is invalid.
451	The fifth diagnosis code entered on the claim is not on file.
452	The fifth diagnosis code entered on the claim is not covered by MassHealth for members of this gender.
453	The fifth diagnosis code entered on the claim is not covered by MassHealth for members of this age.
454	MassHealth use only
455	MassHealth use only
456	This fifth diagnosis code entered on the claim requires review.
457	The fifth diagnosis code entered on the claim is invalid on the date of service entered on the claim.
458	MassHealth use only

Code	Description
459	The revenue code entered on the claim is not the revenue code listed under the prior-authorization number entered on the claim.
460	The revenue code units are missing.
461	The HCPCS laboratory procedure code is missing. The revenue code entered on the claim requires a HCPCS laboratory procedure code be entered on the claim.
462	The procedure code entered on the claim is not required.
463	The revenue code entered on the claim conflicts with the procedure code entered on the claim.
464	The units of service are missing.
465	MassHealth use only
466	MassHealth use only
467	The revenue code entered on the claim is incorrect for the service entered on the claim.
468	The revenue code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
469	The revenue code entered on the claim was not covered by MassHealth for this coverage type on the date of service entered on the claim.
470	The revenue code entered on the claim was not covered by MassHealth for this coverage type on the date of service entered on the claim.
471	The revenue code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
472	The revenue code entered on the claim was not covered by MassHealth for this coverage type on the date of service entered on the claim.
473	The revenue code entered on the claim was not covered by MassHealth for this coverage type on the date of service entered on the claim.
474	Revenue codes 360-369 entered on the claim are not covered by MassHealth on the same date of service entered on the claim when billed with revenue codes 490-499.
475	The revenue code entered on the claim is not on file for the date of service entered on the claim.
476	The revenue code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
477	The revenue code pricing entered on the claim requires review.
478	The revenue code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
479	The revenue code entered on the claim does not have a rate on file.
480	The revenue code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
481	Enter the procedure code description on the claim when billing an unlisted procedure code.
482	Pharmacy claims must be billed through POPS.

Code	Description
483	The claim must be billed as mental health/substance abuse only. Bill the MassHealth Behavioral Health Partnership.
484	The member's coverage type is buy in/subsidy only.
485	MassHealth use only
486	The procedure code entered on the claim is not covered for members enrolled in this coverage type. The member is enrolled in MassHealth Basic.
487	The procedure code entered on the claim is not covered for the member's coverage type.
488	The procedure code entered on the claim is not covered for members enrolled in this coverage type. The member is enrolled in MassHealth Limited.
489	The procedure code entered on the claim is not covered for members enrolled in this coverage type. The member is enrolled in MassHealth Family Assistance.
490	The EOB requires review.
491	The EOB requires review.
492	The EONMB requires review.
493	The Utilization Review letter is incomplete.
494	The services entered on the claim contain a combination of Medicare Parts A and B charges. This claim must be split-billed according to crossover claim guidelines.
495	The EOB requires review.
496	The documentation requires review.
497	The EOB requires review.
498	The EOB requires review.
499	The EOB requires review.
500	MassHealth use only
501	MassHealth use only
502	The prescription origin is either invalid or conflicts with other prescription information. Correct the prescription origin entered on the POPS transaction.
503	The EOB requires review.
504	This adjustment claim requires review.
505	MassHealth use only
506	The first TPL carrier code entered on the claim is invalid.
507	MassHealth use only
508	MassHealth use only
509	The former TCN entered on the resubmittal claim is invalid. Correct the former TCN entered on the resubmittal claim.
510	MassHealth use only

Code	Description
511	This claim requires review.
512	The former TCN entered on the resubmittal claim is invalid.
513	The former TCN entered on the resubmittal claim is invalid. The original claim submission was received for processing more than 90 days after the billing deadline. You may request a 90-day waiver.
514	MassHealth use only
515	The resubmittal entry entered on the claim requires a former TCN be entered on the claim.
516	The member has other health insurance.
517	Attachment carrier code conflict.
518	MassHealth use only
519	This returned-money or void transaction requires review.
520	This claim has been denied after medical review.
521	The from date of service is either missing or invalid.
522	The member identification number entered on the claim is ineligible on the date of service entered on the claim. Verify the RID number through REVS.
523	The member identification number entered on the claim is not on the eligibility file. Verify the RID number/eligibility through REVS.
524	This claim requires review.
525	MassHealth use only
526	MassHealth use only
527	MassHealth use only
528	The EOB is missing. The claim requires that an EOB is attached or the claim may be billed electronically using the COB transaction.
529	MassHealth use only
530	The NDC entered on the POPS transaction is incomplete. Correct the NDC entered on the POPS transaction.
531	The supplier's invoice is missing. The procedure code entered on the claim requires a supplier's invoice.
532	The acquisition cost is missing.
533	The interim bills are not payable by MassHealth.
534	The discharge bills are not payable by MassHealth.
535	MassHealth use only
536	The managed care referral number entered on the claim does not match the member's PCC entered on the claim, or the managed care referral number entered on the claim is invalid.
537	The managed care referral number is missing.

Code	Description
538	The time of admission entered on the claim indicates that the referral number entered on the claim is invalid when the urgent-care referral number is entered on the claim.
539	The mental-health or substance-abuse treatment service entered on the claim must be billed to the Massachusetts Behavioral Health Partnership.
540	The mental-health/substance-abuse services entered on the claim must be billed to the Massachusetts Behavioral Health Partnership. This claim contains both medical and mental-health/substance-abuse services.
541	MassHealth use only
542	The procedure code entered on the claim requires that the place of service indicates the emergency department when the after-hours or no-callback referral number is entered on the claim.
543	This claim requires review. The procedure code entered on the claim requires that an indication of an emergency and place of service indicating the emergency department be entered on the claim.
544	The member has MCO coverage, and therefore, is required to have this service provided by the member's PCC.
545	MassHealth use only
546	MassHealth use only
547	The member has MCO coverage, and therefore, is required to have this service provided by th member's PCC.
548	The member has MCO coverage, was seen in the emergency department, and a screening was provided. Additional inappropriate emergency-department screening services that were provided conflict with the MCO guidelines.
549	The same prescriber and pharmacy DEA numbers are invalid. Correct the prescriber and pharmacy DEA numbers entered on the POPS transaction.
550	The NDC entered on the POPS transaction is not covered by MassHealth for members of this age.
551	The NDC entered on the POPS transaction is not the NDC listed under the prior-authorization number entered on the claim.
552	The days' supply entered on the POPS transaction exceeds the amount allowed by the NDC.
553	The date filled entered on the POPS transaction must be on or after the date the prescription was written.
554	The refill date entered on the POPS transaction is more than six months after the date the prescription was written.
555	The location code entered on the POPS transaction conflicts with the place-of-service requirements of the NDC.
556	The member's gender entered on the POPS transaction conflicts with the gender requirements of the NDC.
557	MassHealth use only

Code	Description
558	The date the prescription was written is either missing or invalid. Correct the date the prescription was written entered on the POPS transaction.
559	The authorized number of refills entered on the POPS transaction exceeds the amount allowed.
560	The member is in a Medical Services Control program that restricts a member to a specific provider for the dispensing of drugs.
561	The prescriber DEA number is either missing or invalid. Correct the prescriber DEA number entered on the POPS transaction.
562	The type of prescription is either missing or invalid. Correct the type of prescription entered on the POPS transaction.
563	The authorized number of refills is either missing or invalid. Correct the authorized number of refills entered on the POPS transaction.
564	The authorized number of refills is either missing or invalid. Correct the authorized number of refills entered on the POPS transaction.
565	The number of refills entered on the POPS transaction exceeds the amount allowed.
566	MassHealth use only
567	Prior authorization is required for the NDC. The NDC entered on the POPS transaction requires that prior authorization be obtained.
568	The prior authorization for the NDC is invalid.
569	The days' supply entered on the POPS transaction is less than the minimum amount allowed of the NDC.
570	The quantity entered on the POPS transaction is less than the minimum amount allowed of the NDC.
571	The quantity entered on the POPS transaction exceeds the amount allowed of the NDC.
572	MassHealth use only
573	The member identification number entered on the claim is ineligible for this coverage type. Verify the RID number/eligibility through REVS.
574	This provider is not authorized by MassHealth to perform the services entered on the claim.
575	The provider number entered on the claim is not on the MassHealth provider file. Contact MassHealth Provider Enrollment.
576	MassHealth use only
577	The processor control number is either missing or invalid. Correct the processor control number entered on the POPS transaction.
578	The prior-authorization number or medical certification code is either missing or invalid. Correct the prior authorization or medical certification code entered on the POPS transaction.
579	MassHealth use only
580	MassHealth use only
581	MassHealth use only

Code	Description
582	MassHealth use only
583	The ProDUR conflict code is either missing or invalid. Correct the ProDUR conflict code entered on the POPS transaction.
584	The ProDUR intervention code is either missing or invalid. Correct the ProDUR intervention code entered on the POPS transaction.
585	The ProDUR outcome code is either missing or invalid. Correct the ProDUR outcome code entered on the POPS transaction.
586	MassHealth use only
587	MassHealth use only
588	MassHealth use only
589	MassHealth use only
590	The procedure code entered on the claim exceeds the amount allowed, unless a prior-authorization number is entered on the claim.
591	The procedure code entered on the claim exceeds the amount allowed.
592	MassHealth use only
593	The procedure code entered on the claim requires review.
594	The procedure code entered on the claim conflicts with services billed on previous and current claims provided on the same date of service entered on the claim.
595	The procedure billed on the claim has been paid on previous or current claims.
596	MassHealth use only
597	The procedure code entered on the claim was previously paid for a new-patient or initial-visit. An established-patient or periodic-patient procedure code must be billed to MassHealth.
598	The procedure codes entered on the claim cannot be billed for the same member, on the same date of service entered on the claim.
599	The ProDUR override code is invalid. Correct the ProDUR override code entered on the POPS transaction.
600	The procedure code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
601	The procedure code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
602	The procedure code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
603	The procedure code entered on the claim is not on file for members enrolled in this coverage type on the date of service entered on the claim.
604	The procedure code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.

Code	Description
605	The service entered on the claim is not payable by MassHealth to municipally-based health services providers.
606	The NDC entered on the POPS transaction was not covered by MassHealth on the date of service entered on the claim.
607	The NDC entered on the POPS transaction was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
608	The NDC entered on the POPS transaction is not covered by MassHealth for members enrolled in this coverage type.
609	The NDC entered on the POPS transaction was not covered by MassHealth on the date of service for members enrolled in this coverage type.
610	The NDC entered on the POPS transaction is not covered by MassHealth for members enrolled in this coverage type.
611	The NDC entered on the POPS transaction was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
612	The NDC entered on the POPS transaction is not covered by MassHealth for members enrolled in this coverage type.
614	Prior authorization is required for anti-ulcer drugs. The NDC entered on the POPS transaction requires that prior authorization be obtained.
615	MassHealth use only
616	Prior authorization is required for Ceradase. The NDC entered on the POPS transaction requires that prior authorization be obtained.
617	Prior authorization is required for Neupogen. The NDC entered on the POPS transaction requires that prior authorization be obtained.
618	Prior authorization is required for Prolast. The NDC entered on the POPS transaction requires that prior authorization be obtained.
619	The primary diagnosis code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
620	The primary diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
621	The primary diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
622	The primary diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
623	The primary diagnosis code entered on the claim is not covered by MassHealth for members in this coverage type.
624	The primary diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
625	The primary diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.

Code	Description
626	The second diagnosis code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
627	The second diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
628	The second diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
629	The second diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
630	The second diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
631	The second diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
632	The second diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
633	The third diagnosis code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
634	The third diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
635	The third diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
636	The third diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
637	The third diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
638	The third diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
639	The third diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
640	The fourth diagnosis code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
641	The fourth diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
642	The fourth diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
643	The fourth diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
644	The fourth diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.

Code	Description
645	The fourth diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
646	The fourth diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
647	The fifth diagnosis code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
648	The fifth diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
649	The fifth diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
650	The fifth diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
651	The fifth diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
652	The fifth diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
653	The fifth diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
654	The procedure code modifiers entered on the claim require review.
655	The admission hour is either missing or invalid.
656	This claim requires review.
657	The 90-day waiver request has been denied.
658	MassHealth use only
659	The procedure code modifier entered on the claim does not have a rate on file for the date of service entered on the claim.
660	MassHealth use only
661	The pharmacy dispensing fee entered on the POPS transaction is not on file for the date of service entered on the claim.
662	The mileage service entered on the claim does not have a rate on file for the date of service entered on the claim.
663	MassHealth use only
664	Prior authorization is required for Pulmozym. The NDC entered on the POPS transaction requires that prior authorization be obtained.
665	MassHealth use only
666	Prior authorization is required for immunity drugs. The NDC entered on the POPS transaction requires that prior authorization be obtained.
667	The NDC entered on the POPS transaction requires prior authorization.

Code	Description
668	MassHealth use only
668	Prior authorization is required for antihistamines. The NDC entered on the POPS transaction requires that prior authorization be obtained.
669	The NDC billed on the claim requires review.
670	Prior authorization is required for immunity drugs. The NDC entered on the POPS transaction requires that prior authorization be obtained.
671	Prior authorization is required for this prescription. The NDC entered on the POPS transaction requires that prior authorization be obtained.
673	The number of MLOA days are missing.
674	The from and to dates of service entered on the claim conflict as the member is coded for in long-term care.
675	The number of MLOA and NMLOA days entered on the claim are not payable by MassHealth for this provider type.
676	The MLOA from and to dates entered on the claim in the first occurrence span months. The claim must be split-billed.
677	The MLOA to date entered on the claim in the first occurrence must be on or after the MLOA from date entered on the claim.
678	The number of MLOA days entered on the claim in the first occurrence conflicts with the from and to dates of service entered on the claim.
679	The NDC entered on the POPS transaction requires prior authorization.
680	The MLOA from and to dates entered on the claim in the first occurrence span months. The claim must be split-billed.
681	The NMLOA to date entered on the claim in the first occurrence must be on or after the NMLOA from date entered on the claim.
682	The number of NMLOA days entered on the claim in the first occurrence conflicts with the from and to dates of service entered on the claim.
683	MassHealth use only
684	The number of MLOA days in the first occurrence is either missing or invalid.
685	The MLOA from date in the first occurrence is either missing or invalid.
686	The MLOA to date in the first occurrence is either missing or invalid.
687	The number of NMLOA days in the first occurrence is either missing or invalid.
688	The NMLOA from date in the first occurrence is either missing or invalid.
689	The NMLOA to date in the first occurrence is either missing or invalid.
690	MassHealth use only
691	The number of MLOA days in the second occurrence is either missing or invalid.
692	The MLOA from date in the second occurrence is either missing or invalid.

Code	Description
693	The MLOA to date in the second occurrence is either missing or invalid.
694	The number of NMLOA days in the second occurrence is either missing or invalid.
695	The NMLOA from date in the second occurrence is either missing or invalid.
696	The NMLOA to date in the second occurrence is either missing or invalid.
697	The number of MLOA days in the third occurrence is either missing or invalid.
698	The MLOA from date in the third occurrence is either missing or invalid.
699	The MLOA to date in the third occurrence is either missing or invalid.
700	The number of NMLOA days in the third occurrence is either missing or invalid.
701	The NMLOA from date in the third occurrence is either missing or invalid.
702	The NMLOA to date in the third occurrence is either missing or invalid.
703	MassHealth use only
704	The number of consecutive MLOA days entered on the claim exceeds the amount allowed.
705	The MLOA from and to dates entered on the claim are invalid.
706	The number of NMLOA days entered on the claim exceeds the amount allowed.
707	The NMLOA from and to dates entered on the claim are invalid.
708	The MLOA and NMLOA from and to dates of service entered on the claim are invalid.
709	The MLOA from and to dates entered on the claim in the second occurrence span months. The claim must be split-billed.
710	The MLOA to date entered on the claim in the second occurrence must be on or after the MLOA from date entered on the claim.
711	The number of MLOA days entered on the claim in the second occurrence conflicts with the from and to dates of service entered on the claim.
712	The number of consecutive NMLOA days entered on the claim exceeds the amount allowed.
713	The NMLOA from and to dates entered on the claim in the second occurrence span months. The claim must be split-billed.
714	The NMLOA to date entered on the claim in the second occurrence must be on or after the NMLOA from date entered on the claim.
715	The number of NMLOA days entered on the claim in the second occurrence conflicts with the from and to dates of service entered on the claim.
716	MassHealth use only
717	The MLOA from and to dates entered on the claim in the third occurrence span months. This claim must be split-billed.
718	The MLOA to date entered on the claim in the third occurrence must be on or after the MLOA from date entered on the claim.
719	The number of MLOA days entered on the claim in the third occurrence conflicts with the from and to dates of service entered on the claim.

Code	Description
720	MassHealth use only
721	The NMLOA from and to dates entered on the claim in the third occurrence span months. This claim must be split-billed.
722	The NMLOA to date entered on the claim in the third occurrence conflicts with the NMLOA from date entered on the claim.
723	The number of NMLOA days entered on the claim in the third occurrence conflicts with the from and to dates of service entered on the claim.
724	MassHealth use only
725	The prescription clarification code is either missing or invalid. Correct the prescription clarification code entered on the POPS transaction.
726	The member is not coded for residence with this long-term-care provider on the dates of service entered on the claim.
727	The member is not coded for long-term care.
728	The level-of-care code entered on the claim is not covered by MassHealth.
729	The patient-paid amount entered on the claim is incorrect.
730	The dates of service, number of days, and patient-status codes entered on the claim conflict.
731	The MLOA from and to dates entered on the claim in the first occurrence conflict with the from and to dates of service entered on the claim.
732	The MLOA from and to dates entered on the claim in the second occurrence conflict with the from and to dates of service entered on the claim.
733	The MLOA from and to dates entered on the claim in the third occurrence conflict with the from and to dates of service entered on the claim.
734	The NMLOA from and to dates entered on the claim in the first occurrence conflict with the from and to dates of service entered on the claim.
735	The NMLOA from and to dates entered on the claim in the second occurrence conflict with the from and to dates of service entered on the claim.
736	The NMLOA from and to dates entered on the claim in the third occurrence conflict with the from and to dates of service entered on the claim.
737	MassHealth use only
738	The member is not coded for residence with this long-term-care provider.
739	The member is not coded for long-term care.
740	The management minutes code is either missing or invalid.
741	The member is not coded for this casemix code. The casemix code refers to the level of functioning for the member.
742	The member is not coded for this casemix code. The casemix code refers to the level of functioning for the member.
743	MassHealth use only

Code	Description
744	MassHealth use only
745	MassHealth use only
747	The usual charge is either missing or invalid. Correct the usual charge entered on the POPS transaction.
748	The total charge is missing.
749	The total charge is required.
750	A referring provider number is required for chiropractor services.
751	The diagnosis code entered on the claim requires review.
752	The HID targeted-drug supply entered on the POPS transaction has reached the emergency amount allowed.
753	The from date of service entered on the claim must be on or after the admission date entered on the claim.
754	The Certification for Payable Abortion form requires review.
755	Certification for Payable Abortion form missing. The procedure code entered on the claim requires a Certification for Payable Abortion form.
756	The Certification for Payable Abortion form is incomplete.
757	The Certification for Payable Abortion form is not completed in accordance with state and federal regulations.
758	The Medical Necessity form is incomplete.
759	MassHealth use only
760	The MLOA and/or NMLOA entered on the claim is invalid for long-term-care contractual providers.
761	Long-term-care contractual providers are not casemix providers.
765	The pay-to provider number entered on the claim is not a group provider number.
766	The member is restricted to a case-management program.
767	The servicing provider entered on the claim is not a member of the group practice as indicated by the pay-to provider number entered on the claim.
768	MassHealth use only
769	The number of days entered on the claim conflicts with the units of service entered on the claim.
770	The days or units entered on the claim exceed the amount allowed for the procedure code entered on the claim.
771	The prior-authorization number entered on the claim was denied.
772	The procedure code modifier entered on the claim is invalid for the procedure code entered on the claim.
773	This claim requires review.

Code	Description
774	The anesthesia units entered on the claim exceed the amount allowed for the procedure code entered on the claim.
775	The procedure code entered on the claim requires review.
776	The percentage-of-charge rate entered on the claim is not on file.
777	The date of service entered on the claim must precede the expiration date of the prior-authorization number entered.
778	The prior-authorization number entered on the claim is not on file.
779	The primary diagnosis code entered on the claim is not valid as a primary diagnosis code.
780	Second Surgical Opinion letter missing. The procedure code entered on the claim requires a Second Surgical Opinion letter.
781	The Second Surgical Opinion letter does not meet State regulations.
782	The incentive days entered on the claim conflict with the incentive days on file.
783	The incentive rate entered on the claim conflicts with the incentive rate on file.
784	MassHealth use only
785	MassHealth use only
786	MassHealth use only
787	MassHealth use only
788	MassHealth use only
789	MassHealth use only
790	MassHealth use only
791	MassHealth use only
792	MassHealth use only
793	MassHealth use only
794	MassHealth use only
795	MassHealth use only
796	MassHealth use only
797	MassHealth use only
798	MassHealth use only
799	MassHealth use only
800	MassHealth use only
801	The location code is either missing or invalid. Correct the location code entered on the POPS transaction.
802	The Medical Necessity form requires review.
803	MassHealth use only

Code	Description
804	The number of miles is missing.
805	MassHealth use only
806	MassHealth use only
807	The time of service is either missing or invalid.
808	The number of minutes of waiting time is missing.
809	The number of minutes of waiting time entered on the claim is not payable by MassHealth if the number of miles entered on the claim is less than 40.
810	The servicing provider entered on the claim is ineligible on the date of service entered on the claim.
811	The servicing provider entered on the claim requires review.
812	The diagnosis code entered on the claim requires review.
813	The procedure code entered on the claim requires review.
814	The procedure code entered on the claim is not covered by MassHealth for surgical assistant services.
815	MassHealth use only
816	The immunization status box must be checked on this MassHealth claim form.
817	The clinical evaluation box must be checked on this MassHealth claim form.
818	The clinical evaluation box indicates a need for further diagnosis or treatment, but the results boxes are blank or the results boxes are complete, but the clinical evaluation box does not indicate a need for further diagnosis or treatment.
819	The referral information is missing.
820	The assessment status box must be checked on this MassHealth claim form.
821	The assessment status entry entered on the claim indicates every test or screening required under the EPSDT protocol was performed, but the procedure code modifier is for an incomplete assessment or the assessment status box indicates that every test or screening was not performed, but the procedure code modifier is for an initial or complete assessment.
822	This claim requires review.
823	This claim must indicate whether any test results are still unknown after 30 days.
824	This claim indicates that test results are unknown after 30 days, but the claim was billed less than 30 days from the date of service entered on the claim.
825	The patient status-code indicator entered on the claim is invalid.
826	The member entered on the claim does not have MCO coverage.
827	There is a conflict between the HMO provider and member.
828	The premium amount is either missing or invalid.

Code	Description
831	One of the following conditions exists. (1) The claim with one or more possible Medicare Part B-covered items was paid with an override. The pharmacy should submit the claim to Medicare and rebill within 90 days, if override Other Coverage 4 was used. (2) The claim with one or more possible Medicare Part B-covered items was paid as the primary insurance, since the payment amount is not over $5.
832	MassHealth use only
833	MassHealth use only
834	MassHealth use only
835	The member has Medicare Part D benefits, which limits MassHealth benefits.
836	One of the following conditions exists. (1) The submitted copayment amount (gross amount due) for the Medicare Part D copayment exceeds the $5 limit. (2) Patients in long-term-care are not subject to a copayment. The claim was submitted for a member enrolled in long term care.
837	This claim was denied because it exceeded the 36-month deadline from the date of service entered on the claim.
840	The member has Medicare Part D eligibility and one of the following conditions exists. (1) The MassHealth wrap provisions have been exceeded (that is, the member has already received two or more fills for a given drug). (2) The claim for services during the Medicare Part D wrap period was denied because the limits were exceeded for the first claim (that is, the supply is greater than 30 days). (3) The claim for services during the Medicare Part D wrap period was denied because limits were exceeded for the second claim (that is, the supply is greater than three days).
841	MassHealth use only
842	MassHealth use only
845	This claim requires review.
847	This claim must be submitted on paper to MassHealth.
849	The TPL procedure code entered on the claim is not on file on the date of service entered on the claim.
850	The procedure code modifier entered on the claim requires a servicing provider number be entered on the claim.
851	The procedure code entered on the claim does not have a rate on file.
852	The anesthesia units are not on file on the date of service entered on the claim.
853	The premium type entered on the claim conflicts with the premium type on file.
854	The premium type entered on the claim is not on file.
855	The premium type entered on the claim is invalid.
856	Services must be billed on a daily basis.
857	Services must be billed on a monthly basis.
858	The MCO payment method must be included in the support table.

Code	Description
859	MassHealth use only
860	This claim requires review.
861	The admission date entered on the claim must be on or after the application date entered on the claim.
862	The 837 replacement claim was submitted without a void transaction.
871	The procedure code entered on the claim requires a quadrant designation be entered on the claim.
872	The procedure code entered on the claim conflicts with the tooth number entered on the claim.
873	The tooth number is either missing or invalid.
874	The tooth-surface code is either missing or invalid.
875	The procedure code entered on the claim requires a tooth number be entered on the claim.
876	The procedure code entered on the claim requires a tooth-surface code be entered on the claim.
877	The tooth number entered on the claim conflicts with the tooth-surface code entered on the claim.
878	The tooth number or tooth-surface code entered on the claim is not covered by MassHealth for the procedure code entered on the claim.
879	The procedure code entered on the claim conflicts with the quadrant designation entered on the claim.
880	The tooth number entered on the claim is invalid for the procedure code entered on the claim.
881	The tooth-surface code entered on the claim is invalid for the procedure code entered on the claim.
884	This claim has been denied for medical necessity.
885	This claim is either considered a duplicate or is a submission error.
886	The medical records are missing. The procedure code entered on the claim requires the medical records.
887	The medical record is incomplete.
888	The final billing deadline has been exceeded.
889	The fiscal year for the date of service entered on the claim is closed.
890	Invalid procedure code for Line A.
891	The EPSDT-assessment procedure code must be billed on line A of this claim form.
892	The procedure code entered on the claim requires a modifier when billed with the place-of-service code entered on the claim.
893	The procedure code entered on the claim requires that the name and provider number of the referring provider be entered on the claim.
894	MassHealth use only
895	The procedure code entered on the claim does not have a rate on file.

Code	Description
896	The health plan coverage is under review.
897	The explanation of benefits (EOB) attachment requires further review for the billing deadline.
898	This claim requires review.
899	The date of service entered on the claim must be on or after the MMIS claims processing date entered on the claim.
900	The pay-to provider number entered on the claim is a billing agency.
901	The NDC file must indicate a standard package size for this item.
902	The provider must have the appropriate specialty code on file to be paid by MassHealth for this drug entered on the POPS transaction.
903	The authorized drug quantity for the NDC on the prior-authorization record has been exhausted.
904	The authorized drug quantity for the NDC on the prior-authorization record has been partially exhausted.
905	No refills are authorized for Schedule II drugs.
906	The prescription type entered on the POPS transaction conflicts with DEA service restrictions entered on the POPS transaction.
907	The prescription type entered on the POPS transaction conflicts with the days supply entered on the POPS transaction.
908	MassHealth use only
909	The NDC file must include a MAC price for this NDC.
910	A temporary recipient identification (RID) number is assigned to this member.
911	The authorized units for the procedure code on the prior-authorization record have been partially exhausted.
912	The number of units entered on the claim conflicts with the number of units authorized on the prior-authorization record.
913	The claim requires review.
914	The prior-authorization transaction entered on the claim requires review.
915	The prior-authorization transaction entered on the claim has been deleted.
916	MassHealth use only
917	MassHealth use only
918	MassHealth use only
919	This claim requires prepayment review.
920	MassHealth use only
921	A temporary recipient identification (RID) number is assigned to this member.
922	This claim requires prepayment review.

Code	Description
923	The claim has been denied after prepayment review by MassHealth.
924	The procedure code entered on the claim must be billed on a MassHealth claim form.
925	The prior-authorization number is missing.
926	MassHealth use only
927	The waiting time entered on the claim is not payable by MassHealth if the round-trip mileage entered on the claim is less than 40.
928	The transportation service entered on the claim requires review.
929	The emergency ambulance services waiting time entered on the claim must exceed 60 minutes.
930	The value code (spend down rate) entered on the claim is invalid.
931	The value code (spend down rate) entered on the claim must be a numeric value.
932	The value code (spend down rate) is invalid for the rate on file.
933	MassHealth use only
934	The NDC entered on the POPS transaction is not on file for the date of service entered on the claim.
935	MassHealth use only
936	The type of bill is either missing or invalid.
937	The number of covered days entered on the claim conflicts with the service units entered on the claim.
938	A revenue code entered on the claim is not on file for the date of service entered on the claim.
939	The provider rate is either missing or invalid.
940	One or more of the revenue codes entered on the claim are not covered by MassHealth.
941	The member's age on the date of service entered on the claim conflicts with the age requirements of the revenue code entered on the claim.
942	The member's gender conflicts with the gender requirements of the revenue code entered on the claim.
943	The revenue code is either missing or invalid.
944	The revenue code entered on the claim conflicts with the rate identification on file.
945	The Second Surgical Opinion letter requires review.
946	The claim tranaction control number is invalid.
947	The claim assignment indicator is invalid.
948	The claim does not indicate if the Medicare payment was Part A or B.
949	The service units entered on the claim must be a numeric value.
950	The EOB does not match the information on file.
951	The Medicare type of service code must be entered in item 24C of the HCFA-1500 claim form.

Code	Description
952	The amount billed to Medicare entered on the claim must be a numeric value.
953	The amount Medicare allowed entered on the claim must be a numeric value.
954	The amount Medicare paid entered on the claim must be a numeric value.
955	The amount billed to Medicare entered on the claim must be a numeric value.
956	The amount Medicare allowed entered on the claim must be a numeric value.
957	The amount Medicare paid entered on the claim must be a numeric value.
958	The Medicare amounts billed, allowed, and paid entered on the claim conflict.
959	The Medicare amounts billed, allowed, and paid entered on the claim conflict.
960	A copy of the original Medicare claim must be submitted with the Medicare EOMB.
961	MassHealth use only
962	The Medicare EOB must be submitted.
963	The rate identification code entered on the claim conflicts with the admission date entered on the claim.
964	The rate identification code entered on the claim conflicts with the treatment authorization code entered on the claim.
965	MassHealth use only
966	The dates of service entered on the claim must be within the approval range.
967	MassHealth use only
968	This claim has already been reversed.
969	The preoperative days were denied during preadmission screening.
970	The preadmission screening number is missing.
971	The preadmission screening number entered on the claim is either invalid or not on file.
972	The preadmission screening number entered on the claim conflicts with the preadmission screening record.
973	MassPRO has determined that the principal procedure code entered on the claim must be performed in another setting.
974	The member identification number entered on the claim conflicts with the member identification number on the preadmission screening record. Verify the RID number through REVS.
975	The admission date entered on the claim conflicts with the admission date on the preadmission screening record.
976	The pay-to provider number entered on the claim conflicts with the provider number on the preadmission screening record.
977	The admission date entered on the claim was denied during utilization review.
978	MassHealth use only

Code	Description
979	The preadmission screening number entered on the claim is inactive on the dates of service entered on the claim.
980	MassHealth use only
981	The EOB requires TPL review.
982	The EOB does not match the information on the claim.
983	The member is enrolled in an MCO plan and the service provided is covered by the MCO.
984	This medical service entered on the claim is covered by the CommonHealth program, which is the member's MCO plan.
985	The service entered on the claim is not covered by the member's CommonHealth program.
986	The out-of-state medical services entered on the claim are not covered by the CommonHealth program, except in the case of emergency.
987	The out-of-state medical services entered on the claim are not covered by the CommonHealth program, except in the case of emergency.
988	This adjustment claim requires review.
989	Because this member has changed benefit programs, your adjustment request has been denied. In order to process your claim correctly, the original paid claim must be voided and a new claim submitted for processing under the new benefit program.
990	The from and through dates of service entered on the claim conflict with member eligibility dates. Verify the RID number/eligibility through REVS.
991	MassHealth use only
992	MassHealth use only
993	The date of service entered on the claim must be on or after the date MassHealth became responsible for MCB claims.
994	The member is a Qualified Medicare Beneficiary and is covered for Medicare coinsurance and deductible claims only.
995	The claim to be reversed has been denied. Please confirm the TCN entered on the claim and other relevant data before attempting another reversal.
996	The type of service is either missing or invalid. This claim is for Medicare Part A.
997	The claim to be reversed cannot be located on the system. Please confirm the TCN entered on the claim and other relevant data before attempting another reversal.
998	Because this member's aid category has changed, your adjustment request has been denied. In order to process your claim correctly, the original paid claim must be voided and a new claim submitted for processing under the new benefit program.
999	This adjustment claim is unknown and does not match the former TCN.

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